Office of Aging and Disability Services

(Formerly Office of Elder Services)

Department of Health and Human Services

State of Maine

State Plan on Aging

October 1, 2012 – September 30, 2016

TABLE OF CONTENTS

VERIFICATION OF INTENT

The State Plan on Aging is hereby submitted for the State of Maine for the period October 1, 2012 through September 30, 2016. The plan includes goals, objectives, strategies and performance measures to be conducted by the Office of Aging and Disability Services, Maine's State Unit on Aging, during this period. The Office of Aging and Disability Services has been given the authority to develop and administer the State Plan on Aging in accordance with the requirements of the Older Americans Act. The Office of Aging and Disability Services is primarily responsible for the coordination of all state activities related to purposes of the Act, such as development of comprehensive and coordinated systems for the delivery of supported services, including health, housing, social and nutrition services; and to serve as the advocate for Maine's older adults.

The Plan is hereby approved by the Governor and constitutes authorization to proceed with the activities under the Plan upon approval by the Assistant Secretary for Aging.

The State Plan hereby submitted has been developed in accordance with all federal statutory and regulatory requirements. The State Agency assures that it will comply with the specific program and administrative provisions of the Older Americans Act.

_____ (Signed)_____
Date Ricker Hamilton, Director
Office of Aging and Disability Services

_____ (Signed)_____
Date Mary Mayhew, Commissioner
Department of Health and Human Services

_____ (Signed)_____
Date Paul LePage, Governor
State of Maine

Introduction

The federal Older Americans Act of 1965 requires all states to prepare a periodic "State Plan on Aging" in order to receive federal funds under the Act. The Maine Office of Aging and Disability Services (OADS) developed this plan for meeting the needs of older and disabled adults in Maine in cooperation with Maine's Aging Network. The goal is to assist elders and adults with disabilities to maintain their independence and to live successfully in their homes and communities. Maine's plan is for a four year period beginning October 1, 2012 through September 30, 2016. The plan reflects the collaborative efforts of the OADS, public and private statewide organizations, service providers, employers, advocacy groups, volunteers, and the public. OADS is committed to working with Maine's Aging Network to ensure delivery of services in a way that maximizes the health, well-being and independence of Maine's disabled and older adults.

Since Maine's last state plan was written, the State Legislature directed that the Office of Elder Services be combined with the Office of Adults with Cognitive and Physical Disabilities to form the Office of Aging and Disability Services. The State Unit on Aging is fully maintained in this merger. The merger combines regional operations under one organizational structure, creates clear lines of communication and coordinates central and regional office functions. This merger better serves people in a coordinated, integrated manner by creating access that is more effective, reducing duplication of effort and improving individual outcomes. This merger is consistent with the integration of direct community services offered to Maine's disabled and aging adults by the Aging and Disability Resource Centers.

There has never been a more critical time for a coordinated, collaborative, and integrated approach to delivering services in Maine. Maine's population is living rurally and aging rapidly, which presents significant and unique challenges in all areas, including employment, health care, transportation, home and community based supports and services, and family care giving. Maine, like other states, is facing significant fiscal challenges. The goals, objectives, and strategies outlined in this plan offer a road map for meeting these challenges. This plan is a working document that will be reviewed annually to ensure that the needs of aging Mainers identified herein are being served by the plan. When necessary, objectives and strategies will be changed to address unmet needs.

This plan, in accordance with AoA requirements, builds on the Area Plans developed by Maine's five area agencies on aging. While those plans reflect the needs specific to the regions they serve, this plan focuses on statewide issues. The public has had opportunities to comment on the plan through public hearings, e-mail and phone. The notice was published in multiple newspapers, interested parties were notified, and the draft plan was available for download from the OADS website. Public comments are incorporated in the final plan. Additional public comment details can be found in Appendix A.

Aging in Maine

As part of the planning process, OADS collaborated with the Maine Association of Area Agencies on Aging to conduct a statewide needs assessment. The assessment included a phone survey of 1000 community dwelling Maine residents age 50 and older conducted by Critical Insights, a series of focus groups conducted around the state with more than 80 seniors, including with underserved populations, and two on-line surveys, one completed by more than 230 caregivers and one completed by more than 160 service providers across Maine. The focus groups and on-line surveys were conducted by the University of New England. The information gathered from this needs assessment was greatly enhanced by two additional projects that were conducted during the two years preceding the drafting of this plan. One, a series of statewide listening sessions hosted during the fall of 2011 by Maine's Long Term Care Ombudsman (LTCOP), resulted in a report issued by the Muskie School of Public Service entitled *Personal Experiences with Long Term Care Services and Supports.* The other was a research project conducted by Legal Services for the Elderly (LSE) that resulted in a report entitled *Legal Needs Assessment of Older Mainers* prepared by the University of Maine Center on Aging.

The Culture of Aging in Maine

An important context for this plan is unrelated to statistics and numbers. The focus groups conducted as part of the statewide needs assessment offered insight into how important it is to understand how older adults experience aging and how their experience impacts their ability to find and fully utilize available services.

Maine elders generally do not think of themselves as old, sometimes even when they are 90. Instead, older adults generally report that they measure their age by their independence; and they are fiercely independent. They acknowledge that physical limitations and the loss of independence are the things they fear most. They also talk openly about feeling vulnerable. They worry about falling, about their homes being in disrepair, about not being able to afford their current living situation, and about their benefits being cut. Many are isolated and lonely. There is a clear sense of longing to be more connected with each other and more valued generally for their wisdom and contributions.

The older adults in our focus groups freely admitted that pride keeps them from asking for help and that they think asking for help is admitting defeat. They are glad to accept help when offered, but otherwise, they will do for themselves for as long as they are able. These older adults also admit that they mostly do not know what resources are available to assist them and they do not know how to find resources when they need them. They also are reluctant to trust people they do not know – if they are going to accept help, it has to be from a trusted source.

The vast majority of people want to age in place in their homes and communities. However, the focus groups demonstrated that not all people have a common understanding of "home" and "community," and it became clear that the importance of

staying in ones "home" and "community" depends upon their cultural context. For instance, Islanders view community as people of shared experience within a defined geographic area. For Tribal and Religious, Ethnic, Language (REL) elders, community is more defined by their familial, ethnic, racial, and language similarities than by geography. For Gay Lesbian Bisexual and Transgendered (GLBT) elders, community is often found with other GLBT people or where they feel safe and accepted. For these groups, staying connected to their "community" is critical – they tend to speak of their "homes" and "communities" synonymously and when they are separated from community, isolation results.

Other people in Maine identify much more with their homes and their region of the state. These people tend to be more individualistic rather than defined as a part of a shared commonality of being. For these people, staying in their "homes" seems to be more vital than remaining connected to a community of people. Given these differences, policies and services need to not only take into account *what* is being delivered but also *how* those services are delivered to older adults living within different cultural contexts.

Maine's Demographics

Maine is not only the oldest state in the nation by median age; it is also the most rural state in the nation. According to the 2010 U.S. Census, 15.9% of Mainers are age 65 or older and 61.3% of Mainers live rurally. This is a challenge when 90% of older Mainers report wanting to remain in their homes and communities as they age.

Thanks to one of the largest concentrations of Baby Boomers, Maine's population is aging faster than any other state. In the last 20 years, our median age rose almost by 9 years, from 33.9 to 42.7. Currently, 22.6% of Maine's total population is 60 and older, meaning that more than 300,000 people in Maine can look to the Area Agencies on Aging (AAAs) for Older American Act services and supports.

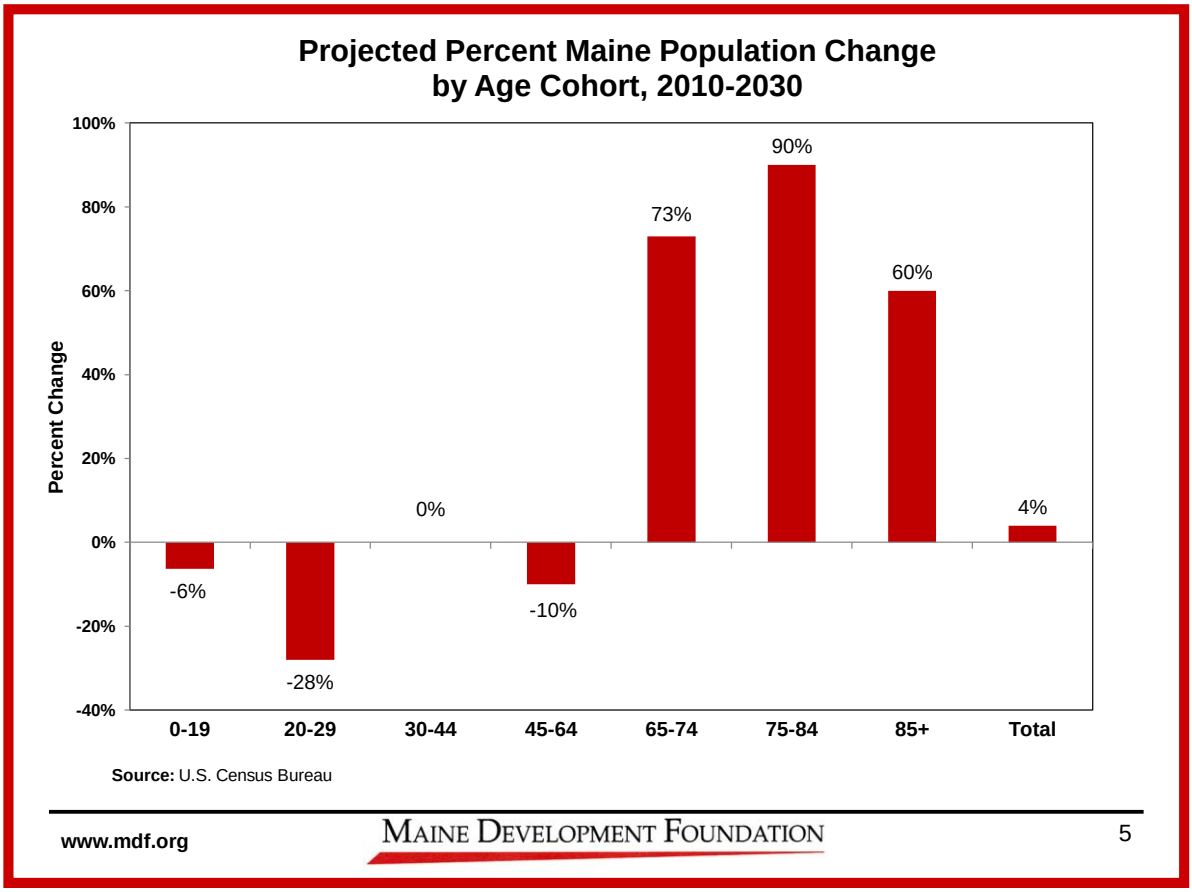
In the four years between 2006 and 2010, Maine's population age 65 and older grew by more than 18,000 from 193,000 to 211,000. By 2030, it is expected that one out of every four Mainers will be over 65. Maine's AAAs can attest to the fact that the Baby Boomer tidal wave is hitting Maine's shores. In 2010, the AAAs served about 74,000 people. In the year that Boomers began turning 65, the number of people served by the AAAs jumped to over 100,000.

In addition, Maine's population of "very old" is growing rapidly. From 1990 until 2009, people age 85 and over grew by 10,000 – a 58% increase. This is putting increased demands on our long-term care system.

As Maine's Baby Boomers age, its workforce population is steadily declining. Maine also has the second smallest percentage of population under 18 in the country and a low birth rate. Our rapidly aging population and slow population growth is expected to continue for two decades. This will result in a steadily decreasing pool of skilled health care and

direct care workers and a steadily aging population in need of medical and home-health care.

Without an in-migration of workers, as Maine's workers retire, employers will find it increasingly difficult to fill jobs with workers whose skills match those of the opened positions. Employers will also have to cope with the significant loss of institutional knowledge that comes when an entire generation of workers, many of whom have worked decades for the same employer, retire at once. Populations experiencing slow growth also find it difficult to attract businesses as population growth and economic growth go hand-in-hand.



Maine's demographics show some interesting gender challenges as well. In 2010, of the nearly 63,000 Maine adults 65 or older who live alone, 71% are women. In addition, more than 72% of those 85 and older in Maine are women. Looking at the Boomer demographic, it is clear that the female-to-male ratio will increase significantly over time. Older women living alone can have some unique challenges, particularly if they lived in traditional households where men physically maintained the home, handled the finances, and drove the family car. Special consideration needs to be taken in relation to the supports older women in Maine need.

More than 137,000 Maine citizens are veterans. It is estimated that approximately 66% of Maine's veterans are 55 and older and 41% are age 65 and older. This means that more than a quarter of Maine's 65 and older population are veterans. Many veterans do not self-identify as such and may not be taking advantage of benefits and services available to them.

Maine is ranked as the 8th healthiest state in the nation. About 17% of those participating in the phone survey consider themselves in fair or poor condition. Residents of northern and far eastern Maine are more likely to report being in fair or poor health and to report having difficulty accessing health and dental care. About 25% of survey respondents have some health limitations related to activities of daily living, like taking a walk or grocery shopping. Those age 65 and older and living alone, are more likely than others to indicate health limitations related to activities of daily living. 80% of those 65 and older are taking at least one prescription drug medication for a health problem.

However, Maine has one of the highest rates of disabilities in the country, and the highest rate in the northeast. A little more than 16% of Maine's people are disabled. About 19% of people over 65 are disabled. Maine's *Snapshot 2011, Maine Workers with Disabilities* report estimates that Maine lost 22,000 jobs during the recession and another 11,000 jobs the six months following the end of the recession. Job losses by those with disabilities during this time far exceeded those without disabilities. In 2009, only 39% of working-age adults with disabilities were employed as compared to 80% of working-age adults with no disabilities. Lack of employment options for people living with disabilities means they are often more reliant on government programs, such as Social Security Disability Income. In 2009, the median household income for a working-age person with a disability, $30,000, was more than half that of a working-age person without a disability. Also in this year, it is estimated that nearly half of Maine's disabled working-age people lived in poverty or near-poverty, living below 200 percent of the Federal Poverty Level.

More than 174,000 Mainers live on Social Security with a mean income of $14,700. 10% of Maine's elders live at or below the Federal Poverty Level, which is higher than the national average. This does not tell the complete story, however, as Maine elders have other financial challenges, including a relatively high income tax rate, high food costs, high electricity costs (41% above the national average) and an aging housing stock that is heated with oil and is generally in need of weatherization and repair. Maine has one of the highest home ownership rates in the country and for the aging population; about 90% of community-dwelling people over age 50 own their homes. This makes home repair a critical issue for many as they age – particularly older women living alone.

For all of our challenges, Maine continues to be one of the safest states in the nation and people, including elders, generally feel safe in their communities. Indeed, our phone survey found that only 8% of those over 50 were somewhat or very concerned about their personal safety in their communities. Those over 55 fear being a victim of a violent crime about as much as those under 55. Things shift, though, when the question turns to personal safety in the home. Only 78% of respondents to our phone survey said they had

no concerns about their personal safety in their homes. While 14% were only a little concerned, 8% were somewhat or very concerned for the personal safety at home. Most people refused to answer why they were concerned, but of those who did, 22% said it was because their home was unsafe for their needs and 14% said it was because they were experiencing violence or caregiver neglect.

The Department of Justice now estimates that one in nine people over the age of 60 will be a victim of elder abuse or exploitation this year. In Maine, this translates into an estimated 33,000 people a year who may be victimized by elder abuse and exploitation. Like the national averages, most elder abuse in Maine is perpetrated by a family member or trusted caregiver. Most elder abuse situations are never reported by the victim or others. It is estimated that 84% of elder abuse cases are never reported. Because older victims usually have fewer support systems and reserves – physical, psychological, and economic – the impact of abuse and neglect is magnified, and a single incident of mistreatment is more likely to trigger a downward spiral leading to loss of independence, a serious complicating illness, and even death.

One troubling type of elder abuse is financial exploitation. This issue weaves tightly with another of Maine's challenges, a growing population of elders who have been diagnosed with some form of dementia. Currently, more than 37,000 Maine people have been diagnosed with some form of dementia and this number is expected to grow to over 53,000 by 2020. One of the first symptoms of dementia is financial difficulty due to loss of abstract thinking. As thousands of Maine's elders have access to assets and diminished decision-making capacity, this makes them easy targets for financial fraud. It's estimated that one in five seniors over 65 have been victimized by financial exploitation, by family members, caregivers and scammers. This is an issue that not only has a terrible impact on the victims, but it also has an impact on our state's economy. Combating financial exploitation of elders must become a top priority.

As mentioned above, Maine has a growing population of elders with dementia. One in eight people aged 65 and older (13%) has Alzheimer's disease. Of those with the disease, an estimated 6% are 65 to 74, 45% are 75 to 84, and 45% are 85 or older. Alzheimer's disease is the fifth leading cause of death for those ages 65 and older. Maine's mortality rate from Alzheimer's is significantly higher than the national average, 35.7% compared to 24.7 deaths per 100,000 people. Alzheimer's and other forms of dementia are still not treated like other forms of diseases; health care professionals do not have a uniform diagnosis and treatment response, community supports and services have not instituted uniform training for community based supports, and family caregivers do not get consistently referred to critical supports and services. In addition, there are insufficient community supports available to provide respite care and adult day care for caregivers who need to work or attend to other daily personal needs, like grocery shopping. The Alzheimer's Association Maine Chapter, in collaboration with many statewide stakeholders, has drafted a state plan for Alzheimer's disease and related dementias. Once adopted, the state will be an active partner in assisting to implement parts of the plan.

In 2010, there were about 10,500 Medicare deaths in Maine but only 4,100 Medicare Hospice deaths. Statewide, hospice utilization rates were 39.2%, just under the national rate of 41.1%. Three counties in Maine, Washington, Hancock and Aroostook, have significantly lower hospice utilization rates, at 20% or under.

According to the 2009 CDC's Behavioral Risk Factors Surveillance System, Maine's rate of heavy and risky alcohol use by those older than 55 is higher than the national average rates. For instance, 5.9 percent of people 55-64 and 5.1% of those 65 or older reported drinking heavily in the past the 30 days where the national rate is 4.5 percent and 3.1 percent for these age groups. Also, 8.2 percent of 55-64 year olds and 3.5 percent of people 65 or older reported binge drinking. Maine's heavy drinking rates among people over 55, and especially over 65, have increased significantly from 2005. Binge drinking and heavy drinking are considered risk factors for alcohol related illnesses and injury. While prescription and illicit drug abuse continues to be a problem for this age category, alcohol abuse is the primary drug of treatment for adults 50 and over at a rate of 90% of all drug treatment.

Maine's Caregivers

It is estimated that there are 154,000 informal family caregivers in Maine. Family caregivers are critically important to the informal network of care for Maine seniors. Many caregivers are trying to do it all on their own, without formal or informal support, and this is taking a toll on caregivers, and ultimately on the economy.

Seventeen percent of the statewide survey participants were providing care for someone living in their house and 21% of the focus group participants were providing care for an older adult. Most caregivers are providing care for either a spouse or a parent, and in many cases, both. As is true nationally, more Maine caregivers are women than men. Three-quarters of self-reported caregivers are performing daily living tasks such as meal preparation, medical care, transportation, and help with finances.

Of those participating in the phone survey, only 19% of family caregivers had sought any type of support or training. An online survey of 236 caregivers revealed 41% or respondents had not utilized any supports or services in providing care in the past year. Most people who did not use available services said they were not aware of the services or could not afford them. Consistently, disabled and older adults and caregivers look to their doctors and health care professionals as a trusted source of information and for referrals to supportive services. This underscores the need to partner with the health care community to ensure that primary care practices and hospitals know about available community supports and services. Friends, family members, and community agencies like the AAAs are other significant referral sources. For younger people, the internet is becoming a trusted referral source.

While friends and family members provide significant support to family caregivers, more than 40% of caregivers say they are reluctant to seek help from any source, including

friends and family. This is often because the caregiver does not want to be a burden or to impose on others, previous requests for help went unanswered or resulted in unreliable care, or the care receiver is resistant to outside help.

Caregiving can have a significant impact on the caregivers. Caregivers are more likely than others to say they have recently experienced little pleasure in things they normally enjoy. Two-thirds of those providing responses to the online survey said they spent less time with other family members and friends, and had to give up things they enjoy.

Caregiving has a direct impact on our economy and workforce. As our workforce shrinks due to the aging of our population, the impact of caregiving on our workers should be a critical focus. Nearly a quarter of the caregivers we surveyed were working part or full time. More than half of these caregivers report that they worry about the person they provide care to while they are at work. Almost half report missing too many days of work because of the care and 35% report phone calls that interrupt their work. Twenty percent of those responding report having less energy at work because they are providing care. 50% of all respondents indicated that at some point they had changed from full to part time work because of caregiving and nearly 40% reported having reduced their work hours. Nearly 1 in 4 had to take a leave of absence to provide care.

Like other states, Maine is facing a serious challenge in relation to the aging of caregivers caring for those with developmental disabilities. It is estimated that more than 3,500 people with developmental disabilities in Maine are living at home with a caregiver who is over age 60. Because adults with developmental disabilities are living longer, families have a longer responsibility of care and as aging caregivers can no longer provide care, increased focus must be given to planning for the long term care needs of those with developmental disabilities.

Maine's Aging Network

Maine's Aging Network is comprised of four major components: The Office Aging and Disability Services, five Area Agencies on Aging, the Long Term Care Ombudsman Program, Legal Services for the Elderly (LSE), and community providers. However, as noted below, there are two new and exciting collaborative efforts in Maine that are bringing Maine's Aging Network together to provide consistent leadership to meet some of Maine's toughest challenges. These are the Maine Council for Elder Abuse Prevention and the Maine Council on Aging.

The Office of Aging and Disability Services is housed within the Department of Health and Human Services (DHHS). The OADS receives federal and state funds to support programs and services to older and incapacitated adults. Appendix B is a view of the OES organizational structure, and Appendix C shows where the OADS fits within the DHHS. OADS works closely with providers, government agencies, elected officials, advocacy groups, and older adults.

Four of the programs within the Office of Aging and Disability Services are:

- ***Community Services manages programs that involve congregate and home delivered meals, outreach, information and assistance, family caregiver assistance, transportation, senior employment, public education, independent support services, adult day services, independent housing with services, evidence based programs for healthy aging, Senior Medicare Patrol, Aging and Disability Resource Center, federal demonstration grants for Alzheimer's services, legal services and SHIP (State Health Insurance Assistance Program). The unit is supported primarily with Older Americans Act funds, and served over 100,000 people in FY11 through the five AAAs, service providers and LSE.***

- ***Adult Protective Services accepts referrals, investigates allegations of abuse, neglect or exploitation of adults age 18+. The program's purpose is to accept referrals, assess the adult and reported dangers and to provide and arrange for services to protect dependent or incapacitated adults who are unable to protect themselves from abuse, neglect or exploitation. The program petitions Probate Court to become public guardian or conservator for incapacitated adults when no private person is available, willing or suitable to assume responsibility; manages assets of public wards and protected persons; and provides training on mandatory reporting and recognizing and reporting abuse, neglect or exploitation to health care, law enforcement and social service agencies. . It is administered by the Office with staff persons in 12 district offices throughout the state.***

- ***Long Term Care manages programs involving home and community-based services for older and disabled adults in order to avoid or delay nursing home placement. The programs include services related to home based care, Medicaid waiver for elders and adults with disabilities, nursing facility care, residential care facilities, assisted living facilities, home health services and adult family care homes. The unit manages pre-admission functional assessment of applicants for nursing facility care and those seeking home and community-based services through a contract with a single statewide assessing services agency. The unit also manages case management and a provider network for home and community-based services through a contract with one of the Area Agencies on Aging.***

- ***Policy, Planning and Resource Development supports the work of the providers, and advocates in planning for and responding to the needs of Maine's aging population. The unit assesses the needs of older and incapacitated adults, and those with long-term care need; identifies and develops resources to meet those needs; collects and maintains the data and statistics for dissemination to policy makers, government agencies, service providers, advocates, and the public; develops and implements the State Plan on Aging and provides staff support to study committees established by the Legislature and internal DHHS committees as needed.***

Community Providers are the backbone of services to Maine's aging population. They provide services that range from adult day services, long-term care services, and transportation services. Beyond providing services, Maine's provider community is actively engaged in advocacy efforts.

Area Agencies on Aging in Maine offer a variety of services to Maine's older adults, including, but not limited to: congregate and home delivered meals, information and assistance, health insurance and benefits counseling, Medicare education regarding insurance and prescription drug benefits, identification and reporting of health insurance fraud, errors and abuse, family caregiving support and training, educational programming, including chronic disease self-management programs, and adult day services. Maine has five AAAs, all of which are private, non-profit agencies. They are Aroostook Agency on Aging, Eastern Area Agency on Aging, SeniorsPlus, Spectrum Generations, and Southern Maine Agency on Aging. The agencies serve all regions of the state (see Appendix D for a map of their service areas). All of these agencies are designated Aging and Disability Resource Centers. These agencies maintain a statewide association dedicated to statewide aging advocacy and leadership called the Maine Association of Area Agencies on Aging (M4A).

Maine's five AAAs are also designated Aging & Disability Resource Centers (ADRCs) and serve as "one-stop-shops" to answer questions from both older adults and people with disabilities, about a wide range of in-home, community-based, and institutional services. ADRCs are expert at answering questions about in-home care services and all kinds of *long-term support*. The goal is to empower callers to make informed choices about long-term support and to streamline peoples' access to that support.

Long Term Care Ombudsman Program (LTCOP) is a private non-profit agency designated by the State to serve as an advocate and mediator for consumers receiving long-term care through nursing homes and home and community based services. The program receives and investigates complaints from individuals and agencies regarding issues that affect the care, health safety or rights of recipients of long term care. The Ombudsman Program is mandated by federal law and is further defined by Maine state enabling legislation (22 MRSA §5106 and 5107-A), which requires the Office of Aging and Disability Services to assure that Maine has an Office of the Ombudsman. LTCOP's authority extends to those receiving home and community based services.

Legal Services for the Elderly is a private non-profit agency designated by the State and mandated and funded under the Older Americans Act to provide free legal services to individuals age 60 and older statewide. The agency also receives state funding as well as funding from other private and public organizations and individuals to support its activities.

Maine Council for Elder Abuse Prevention. For more than a decade, Maine grassroots and non-profit organizations and government officials have been organizing locally, regionally and statewide to identify, reduce and prevent elder abuse, to support elder

victims and to hold perpetrators accountable. While these efforts have been impressive, until recently, the elder abuse network has been fragmented and efforts were often disconnected. Many groups have been struggling to meet the challenges of this work and were looking for coordinated leadership.

Through the efforts of the Elder Justice Partners in coordination with the Maine Association of Area Agencies on Aging and AARP Maine Chapter, these groups were brought together in late 2011 to form the Maine Council for Elder Abuse Prevention. This is a statewide council made up of state and local efforts to address elder abuse prevention, elder victim support and abuser accountability. The more than 40 members of the Council include state officials, law enforcement officers from all segments of law enforcement, non-profit and corporate leaders and grass roots organizers. State officials, including representatives from OADS Adult Protective Services, the Maine Office of Securities, the Maine Office of Professional and Financial Regulation and the Maine Fire Marshall's Office, are an integral part of the Council, providing leadership and support.

The Council is a broad collaborative partnership with active membership from banks, credit unions, private industry, elder law attorneys, hospitals, health care, nursing and direct care associations, domestic violence projects, sexual assault centers, aging services organizations, educational and research partners, and Maine's 10 active TRIADs, four active elder abuse task forces and one Elder Abuse Multiple Disciplinary Team. The Council provides a unifying vision for elder abuse prevention that leads to action. It fosters awareness of existing resources and efforts and builds opportunities for strong collaboration and coordination. The Council is addressing key issues related to financial exploitation and barriers to the provision of services to victims and to investigation and prosecution of elder abuse.

Maine Council on Aging. In late 2011, a broad coalition of organizations representing the full spectrum of aging services in Maine came together to form the Maine Council on Aging. The mission of the Council is to build a strong, multidisciplinary network that represents the entire aging continuum that works to improve the lives of older adults in Maine, especially those who are vulnerable and disadvantaged, to act as a voice for older adults and the organizations that serve them, and to promote the safety, independence and well-being of older adults.

What are the issues and trends?
What are the challenges and opportunities?

Maine's aging network will have to address needs within available resources. While Maine's aging population continues to grow, the economic downturn has had a direct impact on the provision of services. It is becoming increasingly more challenging to provide services to our aging and rural population without the infusion of additional resources. This situation is compounded by a shrinking direct care worker population. We will need to enhance our system to deliver services to people in rural areas with fewer workers. Strategies will include identifying existing community leaders (for instance

active volunteers, religious leaders, and town officials) and supports (for instance libraries, churches and town halls) within Maine's network of small towns and make sure those leaders and supports know what services exist to help people live in their homes and how to participate in the delivery of and access to those services.

OADS and Maine's Area Agencies on Aging and other service providers and partners in the Aging Network will collaborate to increase efficiencies, reduce duplication of services, and improve strategic planning to increase availability and quality of the services that older adults need most. OADS will partner with service providers in setting goals, objectives, and strategies for addressing some of the most challenging issues and will facilitate the dissemination of information about services to service providers. To the extent possible, OADS will assist service providers with finding ways to centralize and share specialized services across providers, like translation and interpretation services for non-English speakers. Regionally, service providers should be encouraged to establish multi-disciplinary aging and disability resource teams to share information and find ways to wrap services around high needs members in the community. Technology, such as Community Links, can be used to facilitate the ease of referring people to other providers and tracking the services the people receive.

Recently OADS and Maine's five AAAs began utilizing the same data system. **As we move more into evidence based funding and value based purchasing, it becomes ever more important to be able to consistently track data across agencies and to have reliability in the data.** We have agreed to adopt similar definitions and to work together to create a uniform administration system, terminology and data entry protocol.

The aging of Maine's population offers not only challenges, but also significant opportunities. Maine's "young old" – those between ages 60-69 – are generally healthy, active and civic minded. As these people retire from work and turn their attention to their communities, we will have a growing skilled and engaged cadre of volunteers to assist in building strong community-based supports for older adults in need of assistance. It will be critically important to find ways to capitalize on the extraordinary skill and knowledge base the Boomers take with them into retirement. These volunteers can help develop new and creative responses to isolation, solutions to local transportation and housing problems and even design new programs that assist seniors in navigating the evolving health care delivery system.

The Baby Boom generation is so large that as they have entered different stages of life, the economy changes to accommodate their needs. This generation is generally less accepting of the "status quo" and is more likely to actively advocate for the expansion of home and community based supports to assist them aging in their communities. **Supports and services to help people remain healthy and aging well in their communities must meet this need and allow for choice and independence regardless of whether private or public funds are expended for the service.** This generation is also typically more mobile and may be more willing to relocate to access appropriate supports and services. They are actively seeking out and helping to create new co-living

and supported living situations all across the state. We will take advantage of this new willingness to collaboratively design new service delivery models.

Together, we will address the impact of aging on our economy and workforce. We will begin to plan for addressing workforce shortages due to both aging caregiving and look at all strategies, including promoting in-migrations of young, skilled workers. We will work collaboratively with universities to design degree-programs that grow the kinds of skilled workers we need to fill existing jobs, and must seek creative solutions to our adult caregiving needs, for instance fostering partnerships with the private/public groups working to increase quality child care options in Maine. As we focus on growing our workforce, we must place special attention to filling the need for direct care workers and increasing capacity for these workers to meet the complex long term care needs of people with behavioral and developmental health issues.

It is a critical time for aging services to actively participate in Maine's growing movement to transform the delivery of health care. Maine has been a national leader in the movement to transform the delivery of health care, particularly through Maine's Patient Centered Medical Home Pilot and the Bangor Beacon Community. These innovative partnerships are providing better coordination of care through increased primary care and patient supports and are resulting in improved health outcomes, better patient experience and lowered costs. All of Maine's AAAs are engaged with initiatives with Maine hospitals to reduce hospital readmissions for high-risk patients through coaching to improve patient activation and self-management of conditions following hospitalization. They are also working with Aligning Forces for Quality to engage disabled and aging Mainers to become better educated health care consumers. As these new health care systems are designed, it is critically important that older patients have a voice in the redesign. There will be many opportunities for partnership between emerging health care innovation projects and community service providers, like the AAAs. These partnership opportunities come at a time when it is increasingly important to ensure that health care providers know about available supports and services and know how to make referrals to them.

A significant path to better health for Maine people is through changing behaviors to prevent chronic illness and to successfully self-manage it. No matter how great the transformation of Maine's health care system, people managing their own health and changing their own behaviors is the key to overall better community health. Chronic disease self-management and falls management programs need to be available even at home.

Maine caregivers are experiencing ever-increasing challenges in trying to balance their own work and health care needs with the needs of those for whom they are caring. Caregivers need to know that support is available and how to access it. We will partner with employers, health care professionals and others to get the word out about available caregiver supports and services and must work to expand the types of supports available for caregivers, including the creation of local support groups, respite care, and adult day programming. Caregivers particularly need help understanding the legal

aspects of providing care and need to know that free legal services may be available to help them.

The poor economy has left Maine's low-income seniors vulnerable. With increased electricity, oil, gas and food costs, many low-income seniors are challenged; they are increasingly reliant on the federal and state safety net. For instance, reduced funding for LIHEAP in 2011 resulted in many Maine seniors being unable to adequately heat their homes and living in unsafe conditions. Remaining in one's home poses a wide range of challenges. For these older adults health, status, financial means, the condition of their homes, and access to transportation and food play a critical role in determining their degree of independence and their ability to stay in their homes.

Given the aging and rural nature of Maine and the high percentage of people living with disabilities, planning for the special care of aging and disabled adults in a disaster is critically important. Maine's Emergency Management Agency (MEMA) and the American Red Cross since 2006 have operated the *Integrated Mass Care Planning and Operations*. In 2009, the planning moved beyond its focus on sheltering toward creating a holistic approach to planning for all mass care needs, including feeding and functional needs support services. This work has resulted in robust community partnerships and the integration of mass care activities into a cohesive program. The next step is to create regional Functional Support Services Teams (FAST) to provide immediate coordinated responses in times of disaster.

Across all of the surveys used to complete Maine's needs assessment, prominent themes arose about the types of long-term care and supports that people need to remain aging well in their homes and communities. These include:

Transportation: Transportation is a critical support for people in rural Maine as evidenced by the responses to the needs assessment. The statewide survey demonstrated that 83% of residents over 65 are completely independent in relation to transportation. This number dips to 79% for people whose income is under $30,000. For people who use State Funded Home Care Services, only 65% reported they could "always" get to the doctor when needed and only 36% percent could "always" get to the grocery store when needed. For those who are dependent on others to meet their transportation needs, 90% of them rely on friends or family members to meet their needs. When people cannot travel outside of their homes, they become increasingly isolated and depressed. This dependency on others also makes them targets for abuse and neglect.

Both consumers and providers agree that Maine needs to address the issue of transportation. Interestingly, focus group participants seemed to prefer public transportation over a privately run volunteer program. It seems critically important to design solutions locally to ensure that future public transportation design is as accessible as possible. With no additional funding to create new or bolster existing transportation systems, communities will have to find low cost solutions to providing transportation in partnership with the state and federal government.

Access to food and nutrition services: As has been well documented nationally, food insecurity is an increasingly concerning issue. Our survey revealed trends that are consistent with the national averages. Nearly a quarter of Mainers over the age of 50 worry that their food budget will not meet their needs and 11% reported skipping meals or cutting back on the amount and type of food they eat for financial reasons. Younger respondents (14% age 50-64) and those with a lower annual income (22% under $30,000) are more likely to say they have skipped or cut back on meals. While only 4% of all respondents said they constantly worried about food, 10% of those with an annual income under $30,000 reported constant worry. Maine ranks 17% nationally for the prevalence of food insecurity amongst seniors.

Qualified, consistent health, personal and home care workers: Elders participating in our needs assessment indicated they want workers who are trained, trustworthy, and reliable. They want to have consistency with the people who come to their house on a regular basis. They want to have some trust that they will be safe when they let an unknown worker into their homes. There is a common understanding that there are too few workers to meet the current demand and that these workers should be better compensated in both salary and benefits. There is confusion about how to access needed home care and homemaker services and concern about not being able to pay for services. Tribal members, GLBT people and REL community members express concerns about cultural sensitivity and awareness as they navigate the system. When considering training for direct care workers, special consideration should be given to including cultural awareness in dealing with these populations.

Home repair and assistive technology: It is clear that as people age; they are becoming less able to do simple chores around their homes that allow for the basic upkeep of their homes. Older and disabled people may no longer be able to fix a broken storm door or window, repair a damaged rainspout, or even mow their lawns. For low-income people, roof repairs, furnace repairs/maintenance and repairing other failing systems is often not feasible. Others do not trust people they do not know coming into their homes or do not ask for help, failing to make needed repairs that can sometimes result in a lack of personal safety. For those living with disabilities, it is clear that some simple assistive technology devices for the visually impaired, grab bars in various locations in the home, ramps, automatic lights and access to Lifeline or similar services would assist in helping them live more easily at home and in less fear.

Isolation: Isolation plays a major role for many of Maine's elders and disabled adults. 36% of those surveyed said they sometimes or often felt lonely and isolated. For those respondents using the state funded home care services, half had not participated in any type of social activity outside of their home in the last 30 days. The vast majority of people say getting out more often or having visitors would help ease their feelings of isolation. In addition, many people mention wanting communities to establish check-in systems – not necessarily a daily call, but some mechanism that lets isolated people know that someone will check on them from time-to-time.

Easy to understand information: Older adults are resourceful and creative in finding ways to remain in their homes relying on their partners, family members, neighbors, community resources and especially themselves. It is clear that they only go looking for services when they need something specific. Many older adults do not know where to look to find needed services and when they find services, they sometimes have trouble negotiating the system. They have asked for easy to understand information and they want to receive it from various sources in the community, for instance via doctors, public access programming, churches, newsletters, and maybe even from store clerks.

Navigation assistance: People find it difficult to navigate the long-term care system. They particularly find the long-term care assessment process confusing. Many people need help with transitions of care after a discharge from a hospital or a nursing home. In addition, those who are navigating the health care system without a caregiver or other supportive volunteer feel overwhelmed by the process. Our Aging and Disability Resource Centers (ADRCs) will with these systems to enhance accessibility.

Affordable housing: As homeownership becomes economically and physically unmanageable, older people are looking for affordable housing alternatives that come with supports and services. Maine needs to promote our housing challenges as opportunities for developers both locally and nationally to encourage the design of creative living communities and structures that offer affordable permanent and transitional housing options and explore grant and low-interest funding endeavors created in other states that create incentives for these projects.

Maine Office of Aging and Disability Services
Goals and Objectives for 2012-2016

Goal 1 – ***Protect the rights of aging and disabled adults, and enhance the response to elder abuse, neglect, and exploitation.***

Objective 1: Decrease financial exploitation of aging and disabled adults.

- **Strategy 1.1:** Work with Maine Council for Elder Abuse Prevention, Legal Services for the Elderly (LSE), financial institutions, the Maine Office of Securities and the Maine State Bar Association Elder Law Section to create tools to educate seniors to prevent exploitation.

- **Strategy 1.2**: Build strong, collaborative relationships with financial institutions to help them better identify and assist older adults at risk of financial exploitation.

- **Strategy 1.3:** Work with Maine's Area Agencies on Aging to assist with finding sustainable funding for "Money Minders".

- **Strategy 1.4**: Facilitate increased collaboration between local, state, and federal partners to protect the assets of aging and disabled adults.

- **Strategy 1.5**: Work with LSE, the Maine State Bar Association and the legal community to ensure older adults have access to legal representation to restore safety and recover lost income and assets.

- **Strategy 1.6:** Build on the foundation created by the Model Approaches grant to identify needs, develop solutions, and coordinate implementation on a statewide basis for the AAA's/ADRCs to work with LSE, the LTCOP and the Office of the Attorney General to decrease abuse, neglect and financial exploitation.

    - **Measure 1:** OADS will continue to attend MCEAP meetings at least quarterly, to maintain relationships, and encourage continued focus on addressing all issues involving financial exploitation.

    - **Measure 2:** By October 2012, OADS and partners will begin working with financial institutions to update and/or develop training material for front line staff, security, and management personnel of financial institutions.

    - **Measure 3:** By May OADS, in collaboration with partners will begin training all financial institutions to recognize the subtle nuances and red flags of financial exploitation in order to prevent loss.

    - **Measure 4:** By June 2014, OADS will develop and deploy a mechanism to track prevented financial exploitation.

- **Measure 5:** Increase the number of referrals from community partners allegeding financial exploitation by December 2016.

- **Measure 6:** Facilitate the convening of a workgroup by June 2016 to discuss how the private bar and law school can collaborate with the Title IIIB legal service provider and Legal Services Developer to increase the availability of legal representation in cases of elder abuse, neglect, and exploitation.

- **Measures 7:** By December 2015, all five AAAs/ADRCs will be trained on how staff can identify and assist those elders who have been abused, neglected or financially exploited will be complete.

Objective 2: Encourage aging and disabled adults to recognize and report suspected instances of abuse, neglect and healthcare fraud and errors to protect themselves and reduce costs to Federal and State healthcare programs.

- **Strategy 2.1:** Increase self-advocacy and education of people about the signs of elder abuse, how to report it, and what community resources exit to support victims of abuse, neglect, and exploitation.

- **Strategy 2.2:** Increase self-advocacy and education of people about the sides of healthcare fraud and errors and how to report it.

- **Strategy 2.3:** Increase the number of Primary Care Practices that are utilizing screening for abuse, neglect, and exploitation using existing tools and that know about community resources that can assist victims of abuse and exploitation.

- **Strategy 2.4:** Raise awareness of World Elder Abuse Awareness Day.

  - **Measure 1:** Continue to annually promote issuance of a Declaration of Proclamation of World Elder Abuse Awareness.

  - **Measure 2:** Annually for World Elder Abuse Awareness Day and periodically throughout each year, collaborate with MCEAP to increase the number of statewide and local events that heighten awareness of elder abuse.

  - **Measure 3:** Collaborate with MCEAP to develop and distribute to people who access elder services via various community based organizations information about the red flags associated with elder abuse, how a victim can secure help, and how a concerned friend or family member can report abuse.

  - **Measure 4:** By December 2013, OADS, LSE, and AAA/ADRCs will collaborate to provide lunch and learn presentations to PCMH, HH and CCT staff via partnership with Quality Counts.

- **Measure 5:** By January 2015, OADS will work with the Maine Medical Association and the health systems to share information with their members via articles or webinars or presentations about available screening tools, how to report elder abuse, and how to refer victims to community based organizations that can help, like LSE, AAA/ADRCs and local interpersonal violence support centers.

- **Measure 6:** Increase by 25% the number of trained Senior Medicare Patrol (SMP) volunteers annually.

- **Measure 7:** Add 12 additional group healthcare fraud and errors education sessions for beneficiaries.

Objective 3: Provide for ongoing examination of systems that protect people from abuse, neglect, and exploitation and work toward system improvement.

- **Strategy 3.1** Facilitate training with Maine's AAA/ADRCs, LSE, LTCOP, and other community partners for community and institutional providers on abuse, neglect, and exploitation in the role of mandated reporting and increase training opportunities of law enforcement, legal and judicial professionals.

- **Strategy 3.2:** Continue to actively participate with the Maine Elder Death Analysis Review Team and Maine Council for Elder Abuse Prevention as a mechanism for examining systems change.

- **Strategy 3.3:** Work with our community partners to improve the civil and criminal remedies available to address abuse, neglect, and exploitation of aging and disabled adults through appropriate changes to statutes and rules.

- **Strategy 3.4:** OADS' Legal Services Developer will provide systematic advocacy in protecting the rights of older adults and will actively monitor State and Federal legislation affecting Maine's older adults.

    - **Measure 1:** OADS will continue to monitor State and Federal legislative activity on elder rights issues.

    - **Measure 2:** The Legal Service Developer will continue to provide ongoing review and guidance on how proposed State and or Federal legislation may affect the rights of Maine's older and disabled adults.

    - **Measure 3:** OADS and Maine's AAA/ADRCs will work together to increase the number of community and institutional providers who have received training on abuse, neglect, and exploitation and the role of mandated reporting.

    - **Measure 4:** OADS and Maine's AAA/ADRCs will work to increase the number of law enforcement officers, legal and judicial professionals who receive training on abuse, neglect, and exploitation and the role of mandated reporting,

Objective 4: Increase the ability to meet the emergency needs of older and disabled victims of abuse, neglect, and exploitation, including increasing the availability of emergency and transitional housing

- **Strategy 4.1:** Assess the unmet emergency needs of older and disabled victims of abuse, neglect, and exploitation.

- **Strategy 4.2:** Work to develop partnerships and funding systems to meet the specialized emergency and temporary needs of disabled and older victims of abuse, including emergency housing.

    - **Measure 1:** Beginning in December 2012, OADS will establish and begin utilizing emergency, short-term housing or beds for those being abused, neglected or financially exploited.

    - **Measure 2:** By December 2014, OADS will explore and/or develop a tracking mechanism for unmet needs in regards to abuse, neglect or financially exploited older and disabled adults.

    - **Measure 3:** By June 2016, OADS will quantify and analyze data regarding the unmet needs for abused, neglected, or financially exploited older and disabled adults as well as track resolution.

    - **Measure 4:** Convene a task force with members from the Maine's Legislatures Joint Standing Committee on Judiciary, Maine's non-profit legal service providers, the Maine School of Law, the Maine Bar Association and others to identify ways to increase the funds available for the States Title IIIB legal services provider

Objective 5: Improve awareness and access to legal services for aging citizens who at risk of abuse, neglect and exploitation.

- **Strategy 5.1:** Develop and disseminate education materials and activities that increase awareness and understanding of legal issues around health and long-term care options and planning.

- **Strategy 5.2:** Collaborate with the States Title IIIB legal services provider and other stakeholders to evaluate, develop, and disseminate information to increase awareness of and understanding of legal issues by older adults, their families and caregivers.

- **Strategy 5.3:** Support the States Title IIIB legal services provider efforts to assess and track sources of referrals to identify areas of improvement.

- **Measure 1:** By December 2013, the States Title IIIB legal services provider will improve the method of tracking referral sources and begin reporting data to OADS on an annual basis.

- **Measure 2:** By 2014, evaluate and revise, if necessary, existing materials available to consumers, legal service providers and advocates, including education materials, legal manuals, and best practice guides.

Goal 2: Assist aging people and their families to make informed decisions about, and be able to easily access, existing health, and long-term care options.

Objective 1: Increase the availability and consistency of information, outreach and advocacy services related to health care and long-term support options to help people make informed, and cost effective decisions.

- **Strategy 1.1:** Work with the Maine's AAA/ADRCs to reach out to employers, municipalities and health care industry regarding available long-term care options counseling and supports and services.

- **Strategy 1.2:** Facilitate collaboration and cross training to better serve older and disabled adults.

- **Strategy 1.3:** Expand outreach and advocacy to Maine's Native American populations, Maine citizens living on coastal islands, Racial Ethnic Language (REL) communities and those living in rurally isolated areas.

- **Strategy 1.4:** Utilize existing Aging Network communications channels, like the AAA/ADRC newsletters, websites, and public access broadcasts, to increase public awareness of available end-of-life supports and services, including hospice and Physicians Orders for Life Sustaining Treatment (POLST) and about the importance of having advance directives.

- **Strategy 1.5:** Expand education and outreach to ensure implementation of the MDS 3.0 Section Q referral process for residents in nursing facilities wishing to speak to someone about their options for returning to the community.

- **Strategy 1.6:** Review and revise, if appropriate, all education materials and activities that increase awareness and understanding of legal issues around health and long-term care options and planning.

    - **Measure 1:** By June 2013 OADS, in partnership with ADRC's will develop informative and consistent Options Counseling marketing material to be disseminated to employers, municipalities and other health care industries to increase awareness of Options Counseling services.

    - **Measure 2:** OADS will work with the AAAs/ADRCs to implement semi-annual programmatic cross training to better meet consumer needs.

    - **Measure 3:** OADS in partnership with appropriate aging network partners, will annually review and update all marketing and informational materials and websites to reflect current aging and disability services and information.

- **Measure 4:** OADS and Maine's AAA/ADRCs will track marketing impact and consumer inquiries.

- **Measure 5:** Deliver training statewide to nursing facility staff around LTCOP's role as the Local Contact Agency as part of the MDS 3.0 Section Q protocol by Spring 2013 and ongoing.

- **Measure 6:** By June 2013, OADS will represent and promote aging services as an active participant in communities and advisory groups representing diverse and isolated populations.

- **Measure 7:** By January 2013, create a category in the AAA/ADRC data system that tracks the number of people seeking and receiving end of life advice and the number of callers who have advance directives in place.

- **Measure 8:** Beginning January 2014, and using the 2013 data as a reference point, increase the number of persons counseled about end of life advice by 10% annually.

- **Measure 9:** By January 2014, AAA/ADRC staff will be trained by the Maine Hospice Council and Center for End-of-Life Care on end of life supports and services and POLST.

- **Measure 10:** By 2016, Medicare hospice utilization rates will meet or exceed the national average.

- **Measure 11:** By 2016, the number of people accessing AAA/ADRC services who have advance directives will meet or exceed the national average.

Objective 2: Increase the outreach and function of Aging and Disability Resource Centers (ADRCs) as well as ensure that Maine's ADRCs are fully functioning and compliant with Maine's 5 Year ADRC State Plan and National ADRC "fully functioning" criteria as being a single point of entry for community services and options.

- **Strategy 2.1:** Increase training of options counselors by collaborating with others to provide enhanced training on subjects such as: Mental Health Services, MaineCare, Person Centered Planning, and Long Term Care Insurance.

- **Strategy 2.2:** Pursue and implement grant opportunities such as ADRC Enhanced and Sustainability.

    - **Measure 1:** By December 2014, OADS will coordinate at least 4 trainings for ADRC staff on various topics such as Medicaid, long term services and supports, person centered planning, mental health and substance abuse services, long term care insurance, and motivational interviewing to better serve older and disabled adults.

- **Measure 2:** OADS will annually conduct site reviews of each of the five AAA/ADRCs to assess and ensure all AAAs/ADRCs are meeting fully functioning criteria.

Objective 3: Increase the representation of organizations serving those with Intellectual and Developmental Disabilities (IDD) with increasing training programs and support for the IDD population with dementia and their caregivers.

- **Strategy 3.1:** Encourage enhanced collaboration and coordination among ADRCs, Alzheimer's Association, family and professional caregivers of individuals with intellectual/physical disabilities to address issues of dementia.

    - **Measure 1:** By December 2012, implement the Savvy Caregiver Program marketing plan.

    - **Measure 2:** By December 2014, OADS in partnership with the AAAs/ADRCs will review and revise all marketing material to expand marketing and outreach to the IDD population with dementia and their caregivers.

Objective 4.0: Integrate services for aging and disabled adults to facilitate improved access to community services, consistency and transition support.

- **Strategy 4.1:** Implement MDS Section Q protocol to ensure institutionalized persons and their families are aware of community options, including eligibility for services through Maine's Money Follows the Person program.

- **Strategy 4.2:** Work with Maine's AAA/ADRCs to strengthen ADRC's as the community contact for information on community services and options.

- **Strategy 4.3:** Facilitate better collaboration among ADRCs, LTCOP, and CIL to meet the needs of, and advocate for, people transitioning from institutions to home and community settings.

    - **Measure 1:** Develop tracking and monitoring system in collaboration with LTCOP and the Office of Maine Care Services to ensure compliance with the MDS Section Q protocol by end of calendar year 2012.

    - **Measure 2:** Establish protocols for the ADRCs, CIL, and LTCOP delineating respective roles and responsibilities by end of calendar year 2012.

    - **Measure 3:** Develop, facilitate, and ensure delivery of cross training to the ADRC's LTCOP and CIL by end of calendar year 2012 and ongoing.

    - **Measure 4:** Increase the number of community service providers that use electronic referrals systems like Community Links to facilitate a referral to the

ADRC to allow for tracking of results of the referral and to ensure the person referred receives services.

- **Measure 5:** Maine's AAA/ADRCs will work to increase the number of community based service organizations that understand the availability of options counseling to disabled and aging adults through the ADRCs and increase referrals received by those organizations.

Goal 3: ***Enable aging and disabled adults to remain safely in their community ensuring a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers*****.**

Objective 1: Ensure all services and supports are dementia capable.

- **Strategy 1.1:** Support other agencies with furthering the implementation of the Dementia State Plan 2012.

- **Strategy 1.2:** Change the self-directed programs to allow the use of a surrogate for the self-direction of services.

- **Strategy 1.3:** Collaborate with MEMA to ensure for the appropriate and specialized care of people with dementia in a disaster.

    - **Measure 1:** Conduct presentations on elder issues including dementia at MEMA's Disaster Preparedness Conference.

Objective 2: Increase caregiver awareness of and access to support services that will reduce caregiver stress and increase quality of care.

- **Strategy 2.1:** Support the availability of Adult Day Services and Respite services as part of the LTC community services continuum.

- **Strategy 2.2:** Increase awareness of and participation in Maine Family Caregiver Program by promoting the program to public and private organizations that serve people with dementia and to family caregivers of individuals with intellectual and/or physical disabilities with or at risk of dementia.

- **Strategy 2.3:** Development of a statewide marketing plan to expand awareness of family caregiver training available through the Maine Family Caregiver Program.

    - **Measure 1:** To the extent possible, Adult Day and Respite service options are expanded and funding increased, especially to rural areas.

    - **Measure 2:** To the extent possible, Adult Day and Respite service participation is increased through expanded marketing and promotion.

    - **Measure 3:** ADS and Respite Services are embedded into the Community LTC delivery system and the aging services provider network menu of service

    - **Measure 4:** By December 2015, all caregiver materials will be reviewed and revised if necessary.

- **Measure 5:** Increase caregiver participation and support by 15% by December 2016.

- **Measure 6:** Develop a more comprehensive and consistent caregiver assessment tool to assess caregiver eligibility for programs by December 2016.

Objective 3: Increase awareness of and referral by healthcare professionals to AAAs/ADRC's and other appropriate community partners to address the community based supports for their aging and disabled patients.

- **Strategy 3.1:** Expand efforts to promote AAA/ADRC services to healthcare professionals and community partners on the services available for their patients in the community.

  Strategy 3.2: Work to ensure that Community Care Teams utilize services available by ADRCS to support their patients living and aging well in the community.

  - **Measure 1:** Throughout 2013, OADS will work collaboratively with M4A and the AAA/ADRCs to schedule and provide appropriate presentations on the availability and efficacy of options counseling to various health care professionals via the Maine Medical Association, the Maine Hospital Association, Quality Counts, and Maine's health systems.

  - **Measure 2:** Increased facilitated referrals from health care professionals to the ADRCs for Options Counseling via electronic means such as Community Links.

Objective 4: Assist community based organizations to build capacity to meet increasing demands for services with diminishing financial and human resources.

- **Strategy 4.1:** Develop competency-based training to better address the complex needs of Maine's aging and disabled adults.

- **Strategy 4.2:** Expand training available in nursing facilities to community providers to help manage difficult behaviors and other complex needs.

- **Strategy 4.3:** Increase the knowledge and use of consumer directed services.

- **Strategy 4.4:** Increase use of highly trained and managed volunteers at all levels of service provision.

- **Strategy 4.5:** Explore advances in technology that can support aging and disabled adults in their home.

- **Strategy 4.6:** Create public and private partnerships with employers and professional associations to address economic impact of family caregiving on the workforce and to support the creation of Adult Day Services, respite services and other family caregiver supports.

- **Strategy 4.7:** Encourage a formalized structure for managing and retaining volunteer services.

    - **Measure 1:** Semi-annual training is developed and provided to state and community based aging and disability service staff and volunteers.

    - **Measure 2:** Annually update and improve relevant training, incorporating participant feedback, testing, and participation evaluation.

    - **Measure 3:** Volunteer opportunities are offered that align with the interests, availability and abilities of the changing cohorts by December 2013.

    - **Measure 4:** Volunteer management is incorporated into the operational structure of aging network providers by December 2014.

    - **Measure 5:** Volunteer retention is increased as consistently tracked by the AAA/ADRCs.

    - **Measure 6:** Volunteer hours are tracked and seen as human and financial resource assets to provider organizations beginning in the December 2012.

    - **Measure 7:** AAA/ADRC will actively market options counseling including ADS and Respite services to large employees in respective service area by December 2014.

    - **Measure 8:** Large employers offer access to ADS, Respite, and Caregiver support as part their employee benefit package.

    - **Measure 9:** Based on analysis of data collected on the use of assistive technologies through Maine's Homeward Bound (MFP) program, explore alternate service delivery options for this benefit beginning in July 2014.

    - **Measure 10:** By December 2013, promulgate rules on self-direction of services that are consistent across programs regardless of funding source.

Objective 5: Expand options and enhance awareness of community services that foster independence and safety within the community.

- **Strategy 5.1:** Increase ability of ADRC staff to be able to identify the potential unmet needs of consumers at initial contact and to track the outcomes of referrals.

- **Strategy 5.2:** Engage communities and organizations to address home repair and other home environmental needs.

- **Strategy 5.3:** Increase participation in evidence based programs for homebound aging and disabled adults by providing opportunities to participate in these programs in their homes including the promotion of online programs and home care workers who are trained to deliver the programming..

- **Strategy 5.4:** Identify the unmet needs and advocate for appropriate community resources to meet those needs.

- **Strategy 5.5:** Work with other State and local agencies, AAA's, CAPs, MSHA and others as appropriate, to address challenges resulting from rising energy costs.

- **Strategy 5.**6: Increase awareness of AAA/ADRC staff of red flags associated with alcohol abuse and knowledge of appropriate community referral sources.

    - **Measure 1:** By October 2013, all ADRC will begin tracking "outcomes" of referrals in the Statewide Integrated Data System.

    - **Measure 2:** Homebound aging and disabled adults participate in online evidence-based disease and disability prevention programs by December 2015.

    - **Measure 3:** Home care staff is trained as Chronic Disease Self-Management Education (CDSME) program lay leaders by December 2014.

    - **Measure 4:** Increase the number of elders referred by AAA/ADRC staff to drug and alcohol treatment and counseling.

Objective 6: Actively collaborate with State, Federal and local partners to address the high level of food insecurities among Maine's aging population.

- **Strategy 6.1:** Provide nutritious meals to Maine's eligible aging and disabled adults in their home and through convenient community settings

- **Strategy 6.2:** Educate aging and disabled adults about the availability of SNAP, food pantries, MOW's, USDA programs, and congregate dining.

- **Strategy 6.3**: Increase awareness regarding Maine's food insecurity ranking and programs available to help.

    - **Measure 1:** Participation in senior nutrition programs is increased as measured through annual SAMS and NAPIS data.

    - **Measure 2:** Participation in and access to supplemental food programs is increased based on data collected by Maine USDA and DHHS.

Objective 7: Increase access to and utilization of housing, transportation, and direct care services by aging and disabled adults, living rurally.

- **Strategy 7.1:** Partner with DOT and regional transportation providers to find creative solutions to provide transportation services to rural, aging, and disabled adults.

- **Strategy 7.2:** Expand access and utilization of publicly funded transportation in order to address rural isolation of our aging and disabled persons in need of urban-based services.

- **Strategy 7.3:** Promote and support the development of alternative housing and service models such as Naturally Occurring Retirement Communities (NORC) and/or Senior Alliance for Independent Living (SAIL).

- **Strategy 7.4:** Staff and participate in legislatively mandated taskforces.

    - **Measure 1:** By June 2013, the OADS will convene a meeting with officials from Maine DOT, Maine Municipal Association, M4A, the Maine Community Action Association, and other interested community partners to identify transportation challenges faced by Maine's aging and disabled persons to establish an action plan.

    - **Measure 2:** By December 2013, the OADS through its Housing Resource Developer will identify various housing initiatives that are available in Maine and work to update the Office's website with this information.

    - **Measure 3:** By June 2013, the OADS through its Housing Resource Developer will staff a Blue Ribbon Committee to investigate and develop evolving housing alternative for Maine's aging and disabled persons.

Goal 4 – Encourage aging and disabled people to stay active, healthy and connected to their communities through employment, civic engagement, and evidence-based disease and disability prevention programs.

Objective 1: Foster Community connections for aging adults through opportunities for civic engagement.

- **Strategy 1.1:** Partner with MAR, AARP, SCORE, and other community partners to create volunteer opportunities that match the experience and skills of Maine's retired workforce while helping to build capacity to meet the evolving needs of Maine's aging population.

- **Strategy 1.2:** Encourage a formalized structure for managing and retaining volunteer services.

- **Strategy1.3:** Promote the importance and value of volunteering.

    - **Measure 1:** Beginning in the December 2012 OADS and AAA/ADRCs will begin discussion on how to expand and diversify volunteer opportunities within their local communities.

    - **Measure 2:** Maine's retired workforce is aware of available volunteer options by December 2013.

    - **Measure 3:** Within the aging and disability network and current and new volunteer opportunities are created and filled.

    - **Measure 4:** A stakeholder taskforce is created with organizations such as Maine Association of Retirees, AARP, SCORE, and Maine's Commission for Community Service to build Maine's volunteer capacity by December 2013.

Objective 2: Assist aging and disabled adults with barriers to employment to gain skills necessary to re-enter the work force.

- **Strategy 2.1:** Collaborate with public and private organizations to promote the advantages of hiring mature workers.

    - **Measure 1:** OADS will actively participate in meetings of groups and committees that address barriers to employment opportunities for aging and disabled adults and that optimize available training opportunities for participants.

Objective 3*:* Promote and ensure inclusion of Maine's diverse populations in the aging network and communities.

- **Strategy 3.1:** Identify and address the unique needs of socially and geographically isolated aging and disabled adults.

    - **Measure 1:** By December 2013, OADS will serve as aging and disability representative on Island Eldercare Advisory Committee, Tribal Health Network advisory groups and councils.

Objective 4: Enhance and expand evidence based programs and healthy aging activities.

- **Strategy 4.1:** Support the integration of CDSME programs into evolving health delivery systems transformation.

- **Strategy 4.2:** Collaborate with state federal and local partners to expand the reach of evidence programs.

- **Strategy 4.3:** Support evidence-based program sustainability.

    - **Measure 1:** OADS holds Stanford multi-site, multi-program license by December 2012.

    - **Measure 2:** CDSME workshops, participants, implementation partners, host sites, and trained lay leaders are expanded by 25% annually above the goals reached by ARRA-funded CDSMP initiatives.

    - **Measure 3:** Program funding at the point of service is diversified annually beyond federal and state resources to meet the growing demand for senior nutrition services.

    - **Measure 4:** Aging Services delivery and branding is consistent statewide among Maine's aging network partners by December 2014.

    - **Measure 5:** CDSME programs are integrated into and embedded within the healthcare delivery system transformation

    - **Measure 6:** Scheduled CDSME workshop offering are posted on implementation partner and State websites by December 2012 and ongoing.

    - **Measure 7:** Statewide CDSME participation data is tracked via state approved and direct provider access databases by June 2013.

    - **Measure 8:** CDSME program materials are centrally purchased and distributed by December 2013.

Goal 5 – ***Increase programmatic consistency and the appropriate transfer of information between OADS, Maine's AAA/ADRCs, and Aging Network partners, to ensure data integrity, quality, and access to services for aging and disabled adults.***

Objective 1: Promote consistency among the AAA's/ADRC's marketing, branding, and provisions of delivery of services.

- **Strategy 1.1:** Maine's AAA/ADRCs and OADS will standardize service definitions to improve data consistency, interpretation, and integrity.

- **Strategy 1.2:** In collaboration with Maine's AAA/ADRCs, continue to move towards a single statewide integrated data management system.

- **Strategy 1.3:** In partnership with Maine's AAA/ADRCs, State Unit on Aging and the statewide data integration management vendor, will define, develop, and maintain a unified and consistent administrative data system.

- **Strategy 1.4:** Facilitate ongoing collaboration between OADS/Maine's SUA and Maine's AAA/ADRCs on standardization of delivery service.

    - **Measure 1:** By January 2013, OADS and Maine's AAA/ADRCs will be utilizing a standardized set of service definitions and a single administrative data management system hosted by OADS to ensure consistency and integrity of data.

    - **Measure 2:** By January 2014, M4A and Maine's AAA/ADRCs will have standardized the delivery of core services provided by Maine's AAA/ADRCs staff.

Objective 2: Effectively transfer appropriate consumer information between Maine's AAA/ADRCs and Aging Network partners (including Long Term Care facilities, Long Term Care Ombudsman Program, physician practices, and hospitals) to reduce redundancy in connecting people with services, enhancing the consumer experience.

- **Strategy 2.1:** Promote effective relationships with and between state and community organizations and service providers within the evolving health care delivery system to ensure awareness of and referral to most appropriate, cost effective service(s) that meet the individuals' needs (Maine's AAA/ADRCs, PCMH, CCT, housing services, adult day services and in home services).

    - **Measure 1:** Increase use of electronic referrals systems like Community Links among service providers like health care, long-term care, and personal care professionals to Maine's AAA/ADRCs, LSE, LTCOP, and others.

Goal 6: Continue to educate policy makers and state leaders about the aging demographic and encourage policy initiatives that address resource allocation related to this demographic shift.

Objective 1: Provide concise current, accurate, user-friendly data reflective of current trends, projections, and shifts to promote appropriate resource allocation to meet consumer needs.

- **Strategy 1.1:** Monitor the interstate funding formula to assure it reflects changing demographics and policies (Title III-D)

- **Strategy 1.2:** Encourage research on the social and economic impact of aging in Maine.

- **Strategy 1.3**: Educate Maine's business community and policymakers related to the economic impact of Maine's aging demographics.

- **Strategy 1.4:** Educate Maine's public health officials and community leaders about known health measures and needs of Maine's aging population.

    - **Measure 1:** Biannually review Maine's demographics to ensure intrastate funding formula is relevant.

    - **Measure 2:** Make presentations at annual meetings/conferences of business groups such as the Maine Chamber of Commerce related the economic impact of Maine's aging demographics.

Objective 2: Regularly provide useful data to MEMA and other state officials to ensure that all emergency preparedness plans fully integrate the needs of Maine's aging and disabled adults.

- **Strategy 2.1:** Encourage members of Maine's aging network to actively participate in MEMA's efforts to plan for and meet the functional support services of older and disabled adults in a disaster.

- **Strategy 2.2:** Track preparedness plans to ensure they adequately provide for the needs of older and disabled adults.

    - **Measure 1:** By June 2013, OADS will secure and review MEMA's current disaster plans to ensure that the needs of older and disabled adults are being considered.

    - **Measure 2:** OADS will encourage members of the Aging Network to participate in local and statewide disaster planning as appropriate.

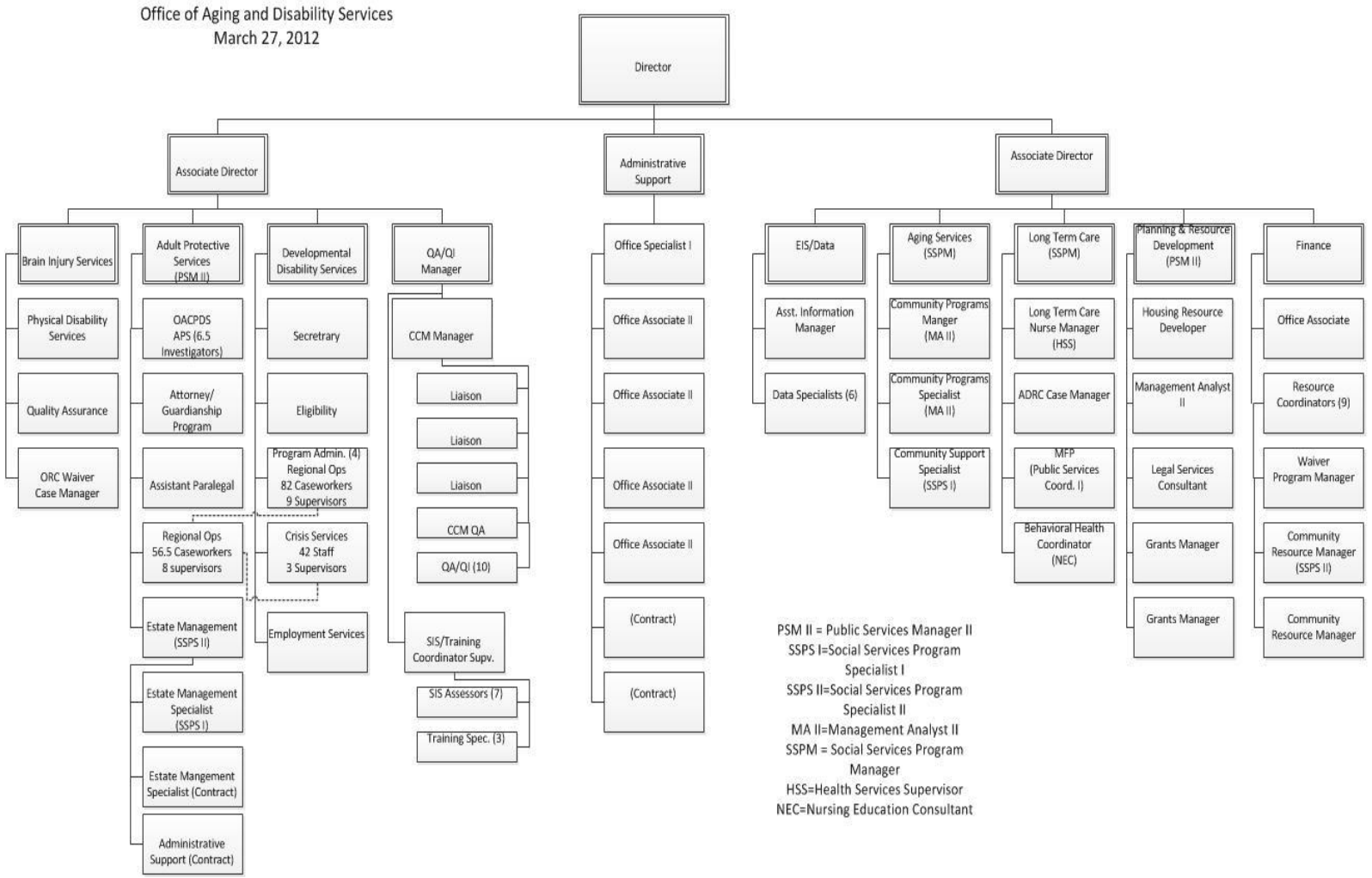
APPENDIX A – PUBLIC COMMENT SUMMARY

Public Hearings have been scheduled at the following dates, times and locations:

Date 1: August 28, 2012, 9 AM
Location 1: Eastern Area Agency on Aging
450 Essex Street
Main Conference Room
Bangor, ME

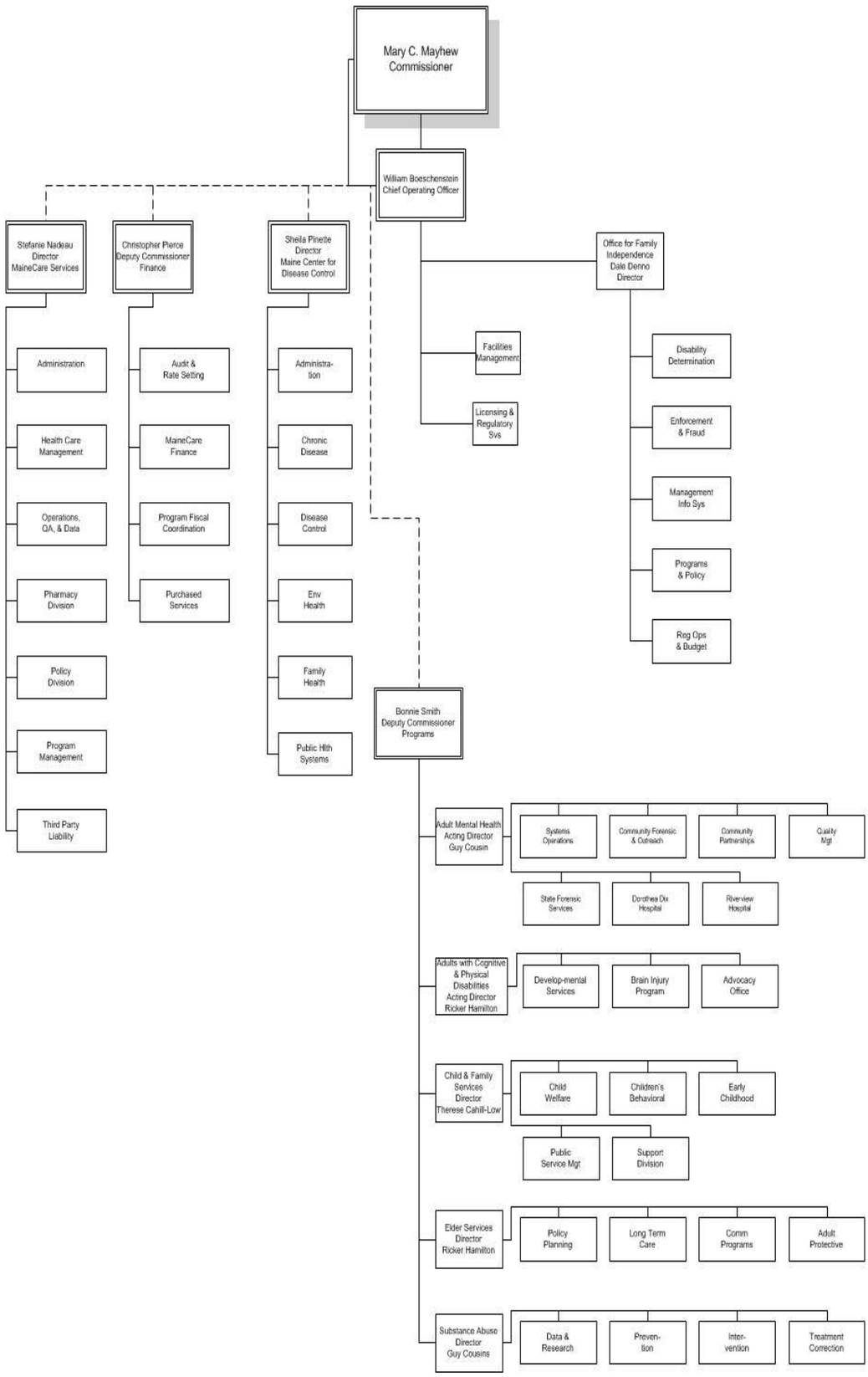
Date 2: August 28, 2012, 1PM
Location 2: 32 Blossom Lane
Conference Rm. 1A
Augusta, ME

APPENDIX B – OES ORGANIZATIONAL CHART

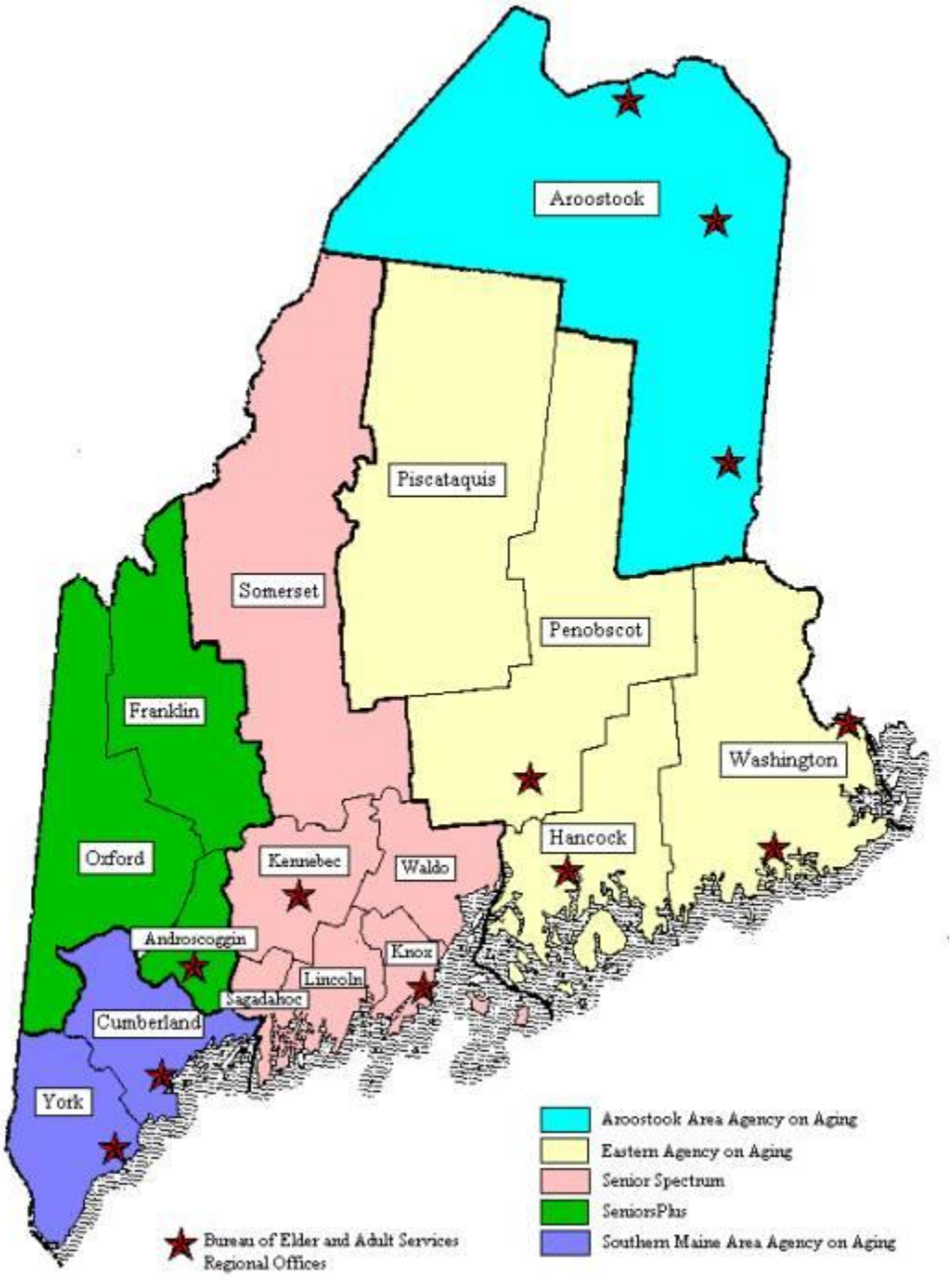


APPENDIX C –DHHS ORGANIZATIONAL CHART

Department of Health and Human Services
Major Offices and Divisions
November 2011



APPENDIX – AAA SERVICE AREAS



APPENDIX E - IFF

Maine Intrastate Funding Formula

AAA Allocation Formula 2012 for Title III Part B, C, and E Funds

Target Populations:	PSA 1 Aroostook	PSA 2 Eastern	PSA 3 Spectrum	PSA 4 Seniors+	PSA 5 Southern	Totals
Persons Age 60+	18,839	59,990	84,710	42,648	94,255	300,442
Persons Age 75+	6,422	19,418	27,150	14,052	31,089	98,131
Minorities (Age 60+)	260	955	1,135	1,185	1,690	5,225
Greatest Social Need						
Non-English Speaking (Age 60+)	465	165	215	445	885	2,175
Have a Disability (Age 65+)	6,014	16,519	11,040	22,894	21,627	78,094
Economic Need (Age 60+ below FPL)	2,109	5,220	7,467	4,300	6,351	25,447
Rural Age 60+	14,083	43,977	48,030	28,567	35,443	170,100
Square Miles	6,828.8	13,539.5	8,111.4	4,416.8	2,488.2	35,384.7
% of Square Miles	19.3%	38.3%	22.9%	12.5%	7.0%	100.0%
Geo-weighted Rural Factor = [Rural Pop Age 60+] x [% of Square Miles] x 5%	136	841	551	178	125	1,831
Target Population Base	48,328	147,085	180,297	114,269	191,465	681,445
Agency Share of Target Population Base	7.09%	21.58%	26.46%	16.77%	28.10%	100.00%
New Funding Formula:						
Base allocation (10% / 5 regions)	2.00%	2.00%	2.00%	2.00%	2.00%	10.00%
Formula allocation (90%*share of target pop.)	6.38%	19.43%	23.81%	15.09%	25.29%	90.00%
New Agency Share of Funds	**8.38%**	**21.43%**	**25.81%**	**17.09%**	**27.29%**	**100.00%**
Share of Funds Under Current Formula	**8.78%**	**21.16%**	**27.02%**	**15.77%**	**27.27%**	**100.00%**
Change from Current Funding Formula	**-0.40%**	**+0.27%**	**-1.21%**	**+1.32%**	**+0.02%**	**0.00%**

Former AAA Allocation Formula from 2007 for Title III Part B, C, and E Funds

Target Populations	PSA 1 Aroostook	PSA 2 Eastern	PSA 3 Spectrum	PSA 4 Seniors+	PSA 5 Southern	Totals
Persons Age 60+	16,300	47,425	65,780	36,320	73,605	239,430
Persons Age 75+	5,670	16,445	23,845	13,470	27,195	86,625
Minorities (Age 60+)	115	695	740	410	945	2,905
Greatest Social Need						
Non-English Speaking (Age 60+)	548	149	379	509	595	2,180
Have a Disability (Age 65+)	6,595	18,150	24,315	14,245	25,875	89,180
Economic Need (Age 60+ below FPL)	2,430	5,810	6,230	3,520	5,480	23,470
Rural Age 60+	12,125	34,705	40,255	20,525	29,800	137,410
Geo-weighted Rural Factor *	*1,326*	664	461	128	104	2,684
Target Population Base	45,109	124,043	162,005	89,127	163,600	583,884
Former Agency Percentage	7.73%	21.24%	27.75%	15.26%	28.02%	100.00%
Base allocation (10% / 5 regions)	2.00%	2.00%	2.00%	2.00%	2.00%	10.00%
Formula Allocation (90% * Agency Percent)	6.95%	19.12%	24.97%	13.74%	25.22%	90.00%
Former Agency Share	8.95%	21.12%	26.97%	15.74%	27.22%	100.00%

* Note: The 2007 calculation of Aroostook's previous geo-weighted rural factor was made in error. Instead of 1,326 the correct number should have been 117.

Data Sources for New Allocation Formula Calculations for Title III, Parts B, C, and E

Target Populations: Persons Age 60+ and 75+: *QT-P1 - Age Groups and Sex* table from the Census 2010 Summary File 1

Minorities (age 60+): The 5-year average number of persons between 2005 and 2009 who were non-Hispanic or non-white in the *S21007A - Age by Hispanic or Latino and Race for the Population 60 Years and Over* table from the U.S. Census Bureau's American Community Survey (ACS) Special Tabulation on Aging, published on the U.S. Agency on Aging's Aging Integrated Database (AGID) web site at: http://www.agidnet.org/DataFiles/ACS/

Greatest Social Need:

Non-English Speaking (age 60+): *S21014A - Age by Ability to Speak English for the Population 60 Years and Over* from the 2005-2009 ACS Special Tabulation on Aging

Have a disability (age 65+): The 3-year average number of persons between 2008 and 2010 who had a disability in the American Community Survey *B18101 Sex by Age by Disability Status* table. Disability status from the 2005 to 2009 Special Tabulation on Aging, since the Census Bureau changed the definition of "disability status" in 2008.

Due to small sample size, the Census Bureau did not publish the 3-year average disability status data for Piscataquis County (Eastern AAA) in the 2008 to 2010. Therefore, the disability rate for Piscataquis County was estimated by taking the unweight average disability rates for the three adjacent counties (Aroostook 36%, Penobscot 33%, and Somerset 38%) in the 65-to-74 and the 75-and-over age groups, and applying them to the total population of those age groups in Piscataquis County.

Economic Need (age 60+ below FPL): The *S21039 - Age by Hispanic or Latino and Race by Poverty Status in Previous Year for the Population 60 Years and Over* table from the 2005-2009 ACS Special Tabulation on Aging

Rural Age 60+: Since the 2005-2009 ACS Special Tabulation on Aging did not include data for the number of older persons living in rural areas, and since the Census Bureau does not plan to publish similar data from Census 2010 until October 2012, this number was estimated by using data from the *P002 - Urban and Rural* table of Census 2000 Summary File 1 to find the total number of persons age 60-and-over who were living in each county, and the number of persons in that same age group who were living in the rural areas of each county. The percentage of older persons living in rural areas was then applied to each county's 2010 census population of persons age 60-and-over.

Geo-weighted Rural Factor: This factor takes population density into account, by first calculating each AAA region's percentage share of the total square miles of land

and water-surface area in Maine. Each AAA's share is then multiplied by 5% of the number of persons age 60-and-above living in the rural portions of each AAA region.

Target Population Base and Agency Percentage: The population base is the sum of all the target populations, plus the number calculated for each region's geo-weighted rural factor. The agency percentage is each AAA's share of the state's target population base.

Funding Allocations for Title III for Parts B, C, and E

The funding allocations for Parts B, C, and E, are based on the same formulas as before. However, the mathematical notations in allocation formulas displayed on page 31 of the 2008-2012 State Plan on Aging are incorrect. The corrected formulas appear below:

$$\frac{(.10*B\$)}{\#AAAs} + \frac{([A:60+] + [A:75+] + [A:M60+] + [A:SN60] + [A:EN60] + [A:R60] + [A:RGW60])}{([60+] + [75+] + [M60+] + [SN60] + [EN60] + [R60] + [RGW60])} * (.90*B\$)$$

PLUS

$$\frac{(.10*C\$)}{\#AAAs} + \frac{([A:60+] + [A:75+] + [A:M60+] + [A:SN60] + [A:EN60] + [A:R60] + [A:RGW60])}{([60+] + [75+] + [M60+] + [SN60] + [EN60] + [R60] + [RGW60])} * (.90*C\$)$$

PLUS

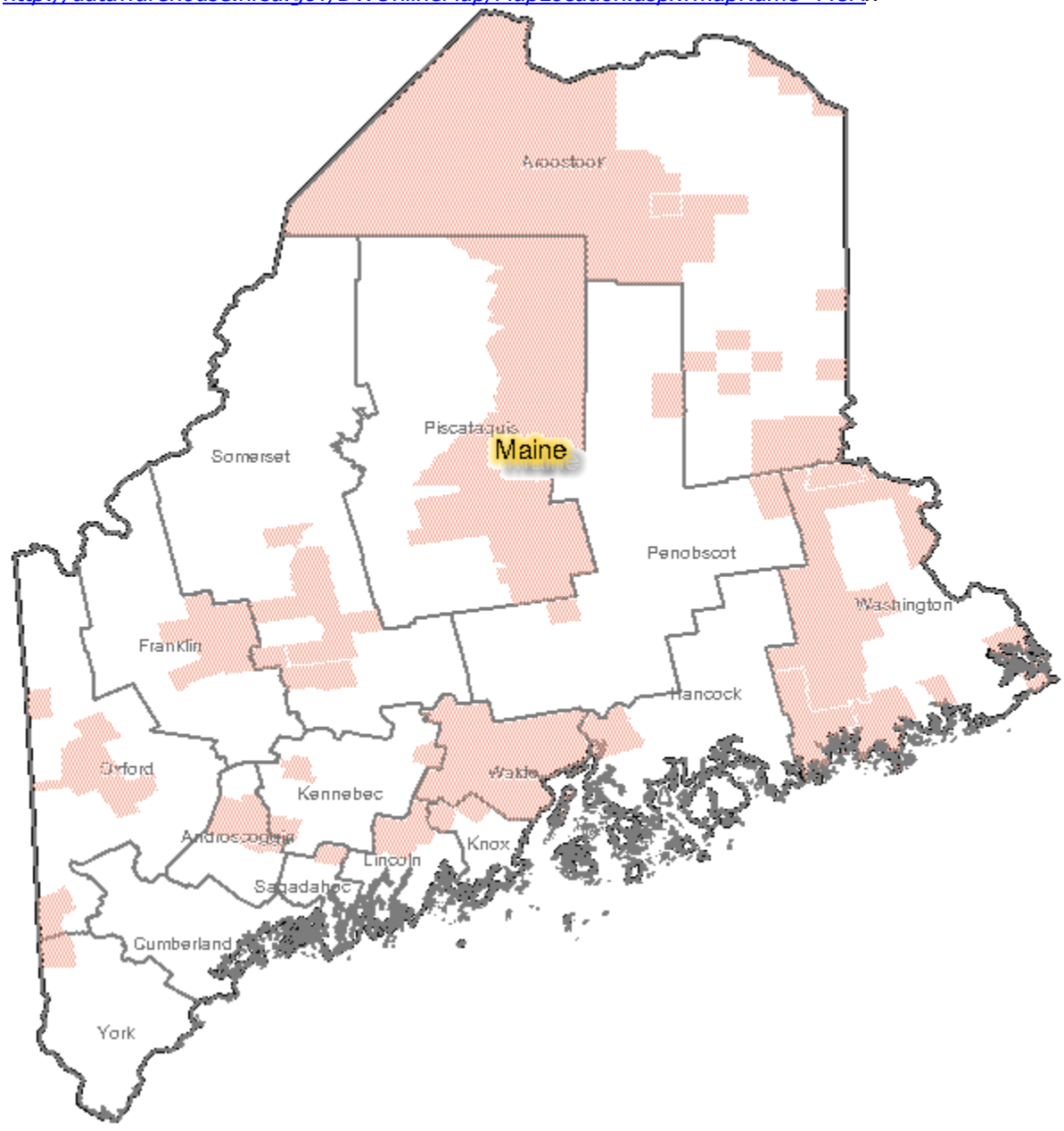
$$\frac{(.10*E\$)}{\#AAAs} + \frac{([A:60+] + [A:75+] + [A:M60+] + [A:SN60] + [A:EN60] + [A:R60] + [A:RGW60])}{([60+] + [75+] + [M60+] + [SN60] + [EN60] + [R60] + [RGW60])} * (.90*E\$)$$

Funding Allocation Formula for Title III, Part D

Target Populations	PSA 1 Aroostook	PSA 2 Eastern	PSA 3 Spectrum	PSA 4 Seniors+	PSA 5 Southern	Totals
Number of persons age 65+ living in medically underserved areas who:						
had a disability	1,102	2,921	1,552	4,704	89	10,368
had incomes below the FPL	297	789	404	1,271	17	2,778
Target Population Base	1,399	3,710	1,956	5,975	106	13,146
New Agency Share	10.64%	28.22%	14.88%	45.45%	0.81%	100.00%
Former Agency Share	11%	53%	12%	23%	1%	100%
Change	0%	-25%	+3%	+22%	0%	0%

Data Sources for New Allocation Formula Calculations for Title III, Part D

The list of Maine towns in each of Maine's Medically Underserved Areas (MUAs) was obtained from the Health Resources and Services Administration (HRSA) Find Shortage Areas tool on the HRSA website at: http://muafind.hrsa.gov/
They are also displayed on the map, below: **Medically Underserved Areas in Maine**
Source: HRSA Data Warehouse Map Tool at:
*http://datawarehouse.hrsa.gov/DWOnlineMap/MapLocation.aspx?mapName=MUA*x



Persons age 65-and-over who had a disability: Since disability status was not included in Census 2010, and since MUA-level disability status data is not available from the current American Community Survey, the number of persons was estimated by using the

P042 - Sex by Age by Disability Status by Employment Status for the Civilian Noninstitutionalized Population 5 Years and Over table from Census 2000 Summary File 3 to calculate the number of persons age 65-and-over with a disability in each town in a current Maine MUA as a percentage of all persons age 65-and-over in each town. This percentage was then applied to the number of persons age 65-and-over in those same towns from Census 2010 Summary File 1 to estimate the number of those persons who had a disability.

Persons age 65-and-over who had incomes below the Federal Poverty Level: The number of persons age 65-and-over with incomes below the FPL was obtained from the *B17001*

Poverty Status in the Past 12 Months by Sex by Age table from 2006-2010 American Community Survey 5-year estimates for each town within a Maine MUA.

APPENDIX F – LIST OF ASSURANCES

Listing of State Plan Assurances and Required Activities
Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and required activities.

ASSURANCES

Sec. 305(a)-(c), ORGANIZATION

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan.

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(i) The State agency shall provide an assurance that the State agency will set specific objectives, in consultation with area agencies on aging, for each planning and service area for providing services funded under this title to low-income minority older individuals and older individuals residing in rural areas

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency; and shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area. In designating an area agency on aging within the planning and service area or within any unit of general purpose local government designated as a planning and service area the State shall give preference to an established office on aging, unless the State agency finds that no such office within the planning and service area will have the capacity to carry out the area plan.

Sec. 306 AREA PLANS

(a)(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—

(A) services associated with access to services (transportation, health services (including mental health services) outreach, information and assistance, (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance; and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

Sec. 307 STATE PLANS

(a)(3)(B)(i) The State agency shall, with respect to services for older individuals residing in rural areas, provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000.

(a)(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(a)(7)(B) The plan shall provide assurances that—

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(a)(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman

program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(a)(10) The plan shall provide assurances that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(a)(11) The plan shall provide that with respect to legal assistance—

(A) the plan contains assurances that area agencies on aging will

(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;

(ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and

(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis;

(B) the plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services;

(C) the State agency will provide for the coordination of the furnishing of legal assistance to older individuals within the State, and provide advice and technical assistance in the provision of legal assistance to older individuals within the State and support the furnishing of training and technical assistance for legal assistance for older individuals;

(D) the plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals; and

(E) the plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing,

utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(a)(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(a)(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include—

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(a)(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(a)(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(a)(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who—

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(a)(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(a)(21) The plan shall—

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(a)(23) The plan shall provide assurances that demonstrable efforts will be made—

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(a)(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(a)(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308 PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705 ADDITIONAL STATE PLAN REQUIREMENTS

(1) The State plan shall provide an assurance that Maine, in carrying out any chapter of this subtitle for which Maine receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;

(2) The State Plan shall provide an assurance that Maine will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

(3) The State plan shall provide an assurance that Maine, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) The State plan shall provide an assurance that Maine will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) The State plan shall provide an assurance that Maine will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant

State law and coordinated with existing State adult protective service activities for—

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) Maine will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order.

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Signature and Title of Authorized Official Date